

U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 28Aug2002

CASE NO.: 2001-BLA-206

In the Matter of

LLOYD L. MARCUM,
Claimant

v.

MILBURN COLLIERY COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Parties-in-Interest

Appearances:

James M. Phemister, Esquire,
Scott Wilkinson, Law Student,
For the Claimant¹

William S. Mattingly, Esquire,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from an apparent duplicate claim for benefits filed on January 5, 2000. (DX 1)², under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.*³ ("Act"). The Act

¹ Mr. Phemister is an attorney with the Washington & Lee University School of Law Legal Practice Clinic. He was assisted at the hearing by a Washington & Lee University law student, Scott Wilkinson. The representation provided to Mr. Marcum in this case by the Legal Practice Clinic was exemplary.

² The following abbreviations are used for reference within this opinion: DX-Director's Exhibits; CX- Claimant's Exhibit; EX- Employer's Exhibit; TR- Hearing Transcript; Dep.- Deposition.

³ The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The

and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis (“black lung disease” or “coal workers pneumoconiosis” “CWP”) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. 20 C.F.R. § 725.101

PROCEDURAL HISTORY

On May 3, 1994, Mr. Marcum filed his first claim for benefits. (DX 39-1). On October 13, 1994, the District Director denied Mr. Marcum’s claim because he failed to establish that he had pneumoconiosis and that he suffered from a total respiratory disability as a result of pneumoconiosis. (DX 39-12). By letter dated November 14, 1994, Mr. Marcum requested a formal hearing. The letter was date stamped as received by the Department of Labor (“DOL”) on January 6, 1995. (DX 39-18). On January 9, 1995, the Claims Examiner notified Mr. Marcum that since he did not appeal the decision of the District Director within 60 days, his claim was considered administratively closed. (DX-39-19).

amended Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the Part 725 regulations, however, were to apply only to claims filed on or after January 19, 2001, *not* to pending cases. The Amendments to the Part 718 and 725 regulations were challenged in a lawsuit filed in the United States District Court for the District of Columbia in *National Mining Association v. Chao*, No. 1:00CV03086 (EGS). On February 9, 2001, the District Court issued a Preliminary Injunction Order which enjoined the application of the Amendments “except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of the case.” On February 20, 2001, I issued a New Regulations Briefing Order, whereby I provided the parties an opportunity to address the application of the new amended regulatory provisions, but which also provided that a party’s “*failure to submit a brief shall be construed as a position that the amended regulations will not affect the outcome of the claim.*” (Emphasis in original). The parties filed briefs. The Employer contended that, in light of the uncertainty regarding the injunction, the hearing should be delayed. On the other hand, the Director stated that the new regulations will not have an effect upon the outcome of this claim. On March 20, 2001, I issued a Ruling and Order on Effect of New Regulations, in which I found that the application of the new regulations will not have an effect on the outcome of this case. Accordingly, I ordered that the hearing would proceed as scheduled and provided the parties with a further opportunity to address the effect of the new regulations in their post-hearing briefs. On August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor’s motion for summary judgment in *National Mining Association v. Chao*, dissolved the Preliminary Injunction, and upheld the validity of the amended regulations.

On March 14, 1996, Mr. Marcum filed his second claim for benefits. (DX 40-1). On August 27, 1996, the Claims Examiner denied Mr. Marcum's claim because he failed to establish the presence of pneumoconiosis, causation, and that he was totally disabled by pneumoconiosis. (DX 40-16). By letter of October 5, 1996, Mr. Marcum requested a hearing before an Administrative Law Judge. (DX-40-17). On November 6, 1996, the Employer, Milburn Colliery Company, filed their Operator Controversion Form CM-970. (DX 40-35). An informal conference was conducted on February 28, 1997 where, among other things, the issue of the most recent coal mine employment was resolved. (DX 40- 47). The case was transferred to the Office of Administrative Law Judges on June 13, 1997. (DX 40-51). A hearing was held before Administrative Law Judge ("ALJ") Jeffrey Tureck on November 17, 1997 in Beckley, West Virginia. (DX 40-61). On August 7, 1998, Judge Tureck issued a Decision and Order Denying Benefits. (DX 40-66). Judge Tureck found the claimant's request for a hearing, dated November 14, 1994, was timely filed and that the May 5, 1994 claim was still pending. Moreover, he found that under § 725.309(d) the 1996 claim merged with the 1994 claim. Judge Tureck noted that the Employer virtually conceded the issue of total disability and denied benefits because the claimant could not establish the presence of pneumoconiosis. On August 3, 1999, Mr. Marcum filed a letter with the DOL requesting a modification of Judge Tureck's decision. Attached to the claimant's handwritten letter were copies of office notes from the Cleveland Clinic. (DX 40-67). No further action was taken on the claim.

On January 5, 2000, Mr. Marcum filed his third claim for benefits. (DX 1). Apparently, this claim was processed as a duplicate claim by the District Director. On February 15, 2000, the employer filed an Operator Controversion Form 970. (DX 18). On October 2, 2000, the District Director awarded benefits to the claimant. (DX 36). On October 6, 2000, the employer notified the DOL that it disagreed with the decision and requested a hearing before the Office of Administrative Law Judges. (DX 37). On November 15, 2000, the case was transferred to the Office of Administrative Law Judges. (DX 41). However, in the transmittal memorandum, the date of filing was noted as May 5, 1994. (DX 42). A hearing was scheduled before me for May 18, 2001 in Parkersburg, West Virginia. On April 26, 2001, the hearing was continued at the request of the claimant to allow additional time to develop medical evidence. A hearing was scheduled before ALJ Michael P. Lesniak on September 12, 2001 in Weston, West Virginia. That hearing was also continued by Order of August 2, 2001 to allow the claimant additional time to develop medical evidence. A hearing was scheduled before me on April 5, 2002 in Parkersburg, West Virginia. By Order of March 4, 2002, the hearing was rescheduled for April 4, 2002 in Charleston, West Virginia.

On April 4, 2002, I held a hearing in Charleston, West Virginia, at which time the claimant and Milburn Colliery Company were represented by counsel.⁴ The parties were afforded the full opportunity to present evidence and argument. At the hearing, Director's Exhibits 1-18, 22-24, 25 (the medical report of Dr. Scott only, x-ray reading excluded), 26, 27, and 29-42 ("DX"), Claimant's Exhibits 1-13 ("CX") and Employer's Exhibits 1-12 ("EX") were admitted into the

⁴ Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment is determinative of the circuit court's jurisdiction.

record.⁵

ISSUES

- I. Whether the instant claim is a duplicate claim pursuant to § 725.309 or a request for modification pursuant to § 725.310?
- II. Whether the claimant's claim for benefits was filed in a timely manner?
- III. Whether the claimant's adopted granddaughter is a dependent for purposes of augmentation of benefits?
- IV. Whether the claimant has pneumoconiosis as defined by the Act and the Regulations?
- V. Whether the claimant's pneumoconiosis arose out of his coal mine employment?
- VI. Whether the claimant's disability is due to pneumoconiosis?

FINDINGS OF FACT

I. Background

A. Coal Miner

The parties agree and I find that the evidence of record establishes that the claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations. (TR 8).

B. Duplicate Claim/Request for Modification

In summary, there were three separate claims filed by the claimant in this case: 5-3-94 (DX 39-1), 3-14-96 (DX 40-1), and 1-5-00 (DX 1). In his Decision and Order dated August 7, 1998, Judge Tureck found that the claimant's 1996 claim merged into the 1994 claim. (DX 40-66). Within one year, on August 3, 1999, the claimant requested modification of Judge Tureck's decision. (DX 40-67). Subsequently, no action was taken by the District Director on the claimant's request for modification. The claimant then filed another claim for benefits in January of 2000.

⁵ On February 1, 2002, I issued an Order excluding DX 19, 20, and 21 as duplicates. I also ruled that an adverse inference will be drawn that had the x-ray of March 29, 2000, been re-read by qualified readers retained by the claimant that such readings would have been positive for the existence of coal workers' pneumoconiosis. I also added that if the employer wished to avoid such adverse inferences, it may do so by funding the deposition of its three readers by the claimant's counsel.

At the hearing the employer argued that the January 5, 2000 filing (DX 1) was a duplicate claim. The claimant maintained that the 2000 claim was a modification request of his original claim for benefits. After considering the argument at the hearing, I made a preliminary ruling that the case should be treated as a request for modification (TR 11) but gave the parties leave to address the issue in their closing briefs. Both parties addressed this issue in their respective closing briefs.

The claimant argued that the District Director was responsible for mishandling two requests for modification that were properly and timely filed by the claimant in this case. Judge Tureck properly merged the 1996 claim into the 1994 claim. Likewise, since the 1994 claim was still properly pending at the time of the filing of the third application (2000) for benefits, the claimant argued that the 2000 claim should have merged into the 1994 claim. The claimant relied on the case of *Plesh v. Director, OWCP*, 71 F.3d 103 (3rd Cir. 1995) in support of his argument.

The employer argued they were denied due process because of the way the District Director mishandled the claimant's request for modification and over the District Director's treatment of the 2000 claim as an apparent duplicate claim. The employer relied on the cases *Consolidated Coal Company v. Borda*, 171 F.3d 175 (4th Cir. 1999) and *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799 (4th Cir. 1998) in support of their position. The employer argued that pursuant to the Court's holding in *Borda, supra*, parties have a right to know under what criteria a claim is being presented for consideration and what potential liability is possible for a claim. Moreover, the employer cited the case of *Lane Hollow Coal, supra*, wherein the Court established a test for determining whether an employer is denied due process by the government's delay in notification of potential liability: Did the government deprive the employer of a fair opportunity to mount a meaningful defense to the proposed deprivation of its property? The employer maintained that no such fair opportunity was given to the employer.

First, I adopt Judge Tureck's ruling that the November 14, 1994 letter from the claimant requesting a formal hearing was timely filed. Due to the repeated mismanagement of this claim by the Director, I find that it is unlikely that the November 14, 1994 letter was actually received when stamped-in. Instead, it is more likely that the November 14, 1994 letter was received closer to the date written on the letter by the claimant. Accordingly, pursuant to § 725.309(d) the 1996 claim merged with the 1994 claim.

I now turn to the claimant's August 3, 1999 request for modification of Judge Tureck's decision that was issued on August 7, 1998. In a letter that was stamped received by the USDOL on August 3, 1999, Mr. Marcum wrote, "I am requesting a modification of the decision made in my Black Lung claim. I am submitting evidence from the Cleveland Clinic which states that my condition is getting worse..." Mr. Marcum attached his medical records from the Cleveland Clinic to the letter. (DX 40-67).

Any communication, no matter how informal, may serve as a request for modification. See *I.T.O. Corp. of Virginia v. Pettus*, 73 F.3d 523 (4th Cir.), cert. denied, 117 S.Ct. 49 (1996). I find that the claimant's letter of August 3, 1999 was without question a request for modification and that it was timely filed by the claimant. Moreover, I find that the Director, for whatever reason, did not act on the claimant's request.

I now turn to the issue of what effect the outstanding request for modification has on the pending claim. In *Borda*, supra, the Court found that the claimant timely filed a request for modification. The Director for whatever reason did not have a copy of the letter as part of the claimant's file and did not act on the request. Nevertheless, the Court held, "Even if the absence of the letter from the government's file is attributable to bureaucratic bungling, that cannot strip Borda of his claim. The content and context of the letter itself, **and not the Director's reaction to it**, must govern whether it was a request for modification." (emphasis added). Pursuant to the Court's holding in *Borda*, supra, I find that the content of the claimant's August 3, 1999 request for modification governs this action, not the Director's inaction to it.

The employer argued that they were denied due process because they were unaware of the claimant's request for modification and because of the Director's mishandling of the 2000 claim lead them to believe that they were litigating a duplicate claim. I disagree. Using the test enunciated in *Lane Hollow Coal*, supra, I find there is no evidence that the employer was deprived of a fair opportunity to mount a meaningful defense. Although, the employer was unaware of the claimant's request for modification when it was filed with the DOL, they did receive the letter as part of the Director's exhibits in November of 2000. There is no question that the Director's actions in this case have lead to confusion regarding the nature of the current claim. However, in the transmittal sheet (DX-42) dated November 15, 2000, the District Director listed the date of filing as May 5, 1994 thereby giving the employer notice that this claim was not being treated as a duplicate claim. The employer had 1 ½ years from the date of the transmittal to the time of the hearing to develop evidence in this matter and to submit rebuttal evidence to any and all medical evidence that had been developed by the claimant. The claimant was available for examination by the employer's physicians. In fact, the employer submitted 12 new exhibits at the hearing in support of their position. The merging of the 2000 claim with the 1994 does not change the law and/or presumptions that will apply to the case.⁶ There is no evidence that the employer was prejudiced in any material way by the omission. Cf. *Grigg v. Director, OWCP*, 28 F.3d 416, 420 n.7 (4th Cir. 1994) (the court could not find a due process violation absent a showing of specific prejudice).

Accordingly, based on the above, I find that the claimant's August 3, 1999 request for

⁶ Unlike in *Borda*, supra, where the merging of the later claim changed what appeared to be a § 718 claim into a § 727 claim. Moreover, the employer was not apprised of the pendency of the 1978 claim until 16 years after the claim was filed. In addition, the employer was only notified of the proper status of the claim the afternoon before the hearing. The Court found in this case that the employer's due process rights were violated.

modification was still pending at the time of the filing of the claim in January of 2000. Therefore, pursuant to § 725.309(d), the 2000 claim merged with the 1994 claim. *Plesh v. Director, OWCP*, 71 F.3d 103 (3rd Cir. 1995). Moreover, in the absence of a showing of specific prejudice, the employer has failed to demonstrate a violation of their due process rights. This case will be treated as a modification request of the 1994 claim.

C. Date of Filing

A claim is deemed timely filed when a claim for benefits filed by a miner is filed within three years after medical determination of total disability due to pneumoconiosis which has been **communicated to the miner**. 20 C.F.R. § 725.308(a). (emphasis added). Pursuant to 20 C.F.R. § 725.308 (c):

There shall be a rebuttable presumption that every claim for benefits is timely filed . . .

The employer argued in their brief that the claimant's claim was not timely filed. The employer based their argument on a statement at the hearing by the claimant that a doctor told him in 1985 or 1986 that he was totally disabled by pneumoconiosis. (TR 24). Specifically, the claimant testified that Dr. Doyle told him that he was totally disabled due to black lung disease. (TR 24). The employer argued that pursuant to § 725.308 the claimant's [1994] claim should be denied as untimely.

The claimant also addressed this issue in his brief. Counsel for the claimant indicated that the claimant's recollection at the hearing was in error as Dr. Doyle first saw the claimant as a patient in May of 1997, three years after the claim was filed. (CX-13).

In *Adkins v. Donaldson Mine Company*, 19 B.L.R. 1-34 (1993), the Board construed "communicated to the miner" to require that a written report of a medical determination of total disability due to pneumoconiosis is actually received by the miner. Moreover, the Board held that oral statements to the miner were insufficient.

In the instant case the claimant is initially entitled to the rebuttable presumption at § 725.308(c) that his claim was timely filed. The employer asserted that the claimant's statement made at the hearing is enough to rebut said presumption. I disagree. Pursuant to the holding in *Adkins*, supra, it is clear that oral statements to a claimant, without more, are not sufficient to meet the requirements of § 725.308(a). Moreover, as the claimant argued in his brief, there exists in the record evidence that Dr. Doyle did not treat the claimant for the first time until 1997, and could not have made this statement to the claimant in 1985 or 1986. (CX-13).

Accordingly, based on the foregoing, I find that the claimant's claim for benefits was timely filed on May 3, 1994. (DX-39-1).

D. Length of Coal Mine Employment

In accordance with Mr. Marcum's representations and his Social Security records, I find that Mr. Marcum was employed in and around coal mines for at least seventeen (17) years. (DX 3, DX 4, DX 2).

E. Responsible Operator

I find that Milburn Colliery Company is the last employer for whom the claimant worked a cumulative period of at least one year or partial periods totaling one year, in accordance with Subpart F (Subpart G for claims filed on or after Jan. 19, 2001), Part 725 of the Regulations. (See TR 9 for stipulation by employer as responsible operator).

F. Dependents

The employer stipulated that the claimant has one dependent for purposes of augmentation, his wife, Juanita Marcum. (TR 9, DX 1, DX 9). The claimant is also claiming his adopted granddaughter, Heather Denise as a dependent. (DX 1). At the hearing the claimant testified his granddaughter was 17 years old and that she had been living with him and his new wife since July of 2001. (TR 16, 27). Heather had previously been attending school in Tennessee. The claimant stated Heather was a junior in school and that he adopted her when she was less than one year old. (DX 40-9, TR 25). The claimant testified that Heather received social security based on the fact that she was a dependent of the claimant. (TR 28). The claimant stated that he contributed whatever money he could, in addition to her social security income, to provide for Heather and her education. (TR 28). Accordingly, I find that Heather Denise is the legally adopted daughter of the claimant pursuant to § 725.220(b) and that she is dependent on him for support pursuant to § 725.221.

I find based on the claimant's testimony and the evidence of record that the claimant has two dependents for purposes of augmentation of benefits under the Act, his wife Juanita and his legally adopted daughter, Heather Denise.

G. Personal, Employment and Smoking History

The claimant was born on January 11, 1936. (DX 1). Mr. Marcum maintained that he was employed by coal mines for seventeen years where he worked as a foreman, shuttle car operator and general laborer. (DX 2). In 1975 Mr. Marcum began working for Milburn Colliery Company as foreman performing his duties in and around coal mines. This was Mr. Marcum's last coal mine employment.

With respect to Mr. Marcum's smoking history, Judge Tureck found that the claimant had

a smoking history in excess of 60 years. (DX 40-66). At the hearing, on cross-examination, Mr. Marcum agreed that he had smoked a pack and a half (1 ½) of cigarettes per day from the age of 18. (TR 20). Mr. Marcum testified that he stopped smoking four years ago. (TR 20). Mr. Marcum was 66 years old at the hearing, therefore, he stopped smoking at the age of 62. (TR 16). Accordingly, I find that the claimant has a smoking history of at least 66 pack years.

II. Medical Evidence

A. Chest X-rays

In the present claim, seventy-nine (79) readings of sixteen (16) X-rays, taken between, July 10, 1970 and July 10, 2001, were submitted. (See Appendix “A”). Of the seventy-nine readings, seven (7) were noted as unreadable, fifty (50) readings were interpreted as negative for coal workers’ pneumoconiosis, and twenty- two (22) X-rays were interpreted as positive.

Also as part of the record was a lung scan of 4-11-77 that was interpreted by Dr. Richmond as showing chronic obstructive pulmonary disease, and bilateral, mild coal workers’ pneumoconiosis. (DX 40). In addition, there was a chest CT performed on 12-6-01 that was interpreted by Dr. Miller as showing no pulmonary mass or nodule. (EX 9).

B. Pulmonary Function Studies

Pulmonary Function Tests are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV₁) and maximum voluntary ventilation (MVV).⁷

Physician Date Exh.#	Age Height	FEV ₁	MVV	FV C	Trac- ing	Compr e- hension Cooper- ation	Qualify* Conform**	Dr.’s Impression
University of VA 3-27-83 DX 40	47	3.26		3.99	----	-----	No* No**	

⁷ Dr. Fino validated the 3-27-83, 8-31-94, and 2-19-97 pulmonary function studies. (DX 40). Dr. Ranavaya validated the 8-31-94 and 3-23-00 pulmonary function studies. (DX 39, DX 10)

Physician Date Exh.#	Age Height	FEV ₁	MVV	FV C	Trac- ing	Compr e- hension Cooper- ation	Qualify* Conform**	Dr.'s Impression
Rasmussen 11-22-83 EX 8 Pre- bronchodilator	47 73"	3.33	120	4.75	Yes	good	No* Yes**	Slight obstructive ventilatory insufficiency
Rasmussen 11-22-83 EX 8 After bronchodilator	47 73"	3.24	109	4.42	Yes	good	No* Yes**	
Daniel 8-31-F DX 39	58 70"	2.04	73	3.30	Yes	good	No* Yes**	Moderate restrictive and obstructive defect
Rasmussen 5-22-96 DX 40 Pre- bronchodilator	60 69.75"	1.95	65	3.67	Yes	good	Yes* Yes**	Moderate, irreversible obstructive vent defect
Rasmussen 5-22-96 DX 40 After bronchodilator	60 69.75"	2.12	80	3.88	Yes	good	No* Yes**	
Castle 2-19-97 DX 19 Pre- bronchodilator	61 70"	1.77	74	3.56	Yes	good	Yes* Yes**	Moderate obstruction with slight response to bronchodilat- ors
Castle 2-19-97 DX 19 After bronchodilator	61 70"	1.95	76	3.64	Yes	good	Yes* Yes**	
Stoller 10-15-98 DX 40 Pre- bronchodilator	62 176 cm	1.52		3.57	Yes		Yes* Yes**	

Physician Date Exh.#	Age Height	FEV ₁	MVV	FV C	Trac- ing	Compr e- hension Cooper- ation	Qualify* Conform**	Dr.'s Impression
Stoller 10-15-98 DX 40 After bronchodilator	62 176 cm	1.32		3.24	Yes		Yes* Yes**	
Stoller 11-20-98 DX 40 Pre- bronchodilator	62 176 cm	1.90		3.53	Yes		Yes* Yes**	
Stoller 11-20-98 DX 40 After bronchodilator	62 176 cm	1.92		3.77	Yes		Yes* Yes**	
Gaziano 3-23-00 DX 10	64 70"	1.53	65	3.82	Yes	good	Yes* Yes**	
Zaldivar 3-29-00 DX 24 Pre- bronchodilator	64 70"	1.30	54	3.06	Yes		Yes* Yes**	Moderate irreversible obstruction
Zaldivar 3-29-00 DX 24 After bronchodilator	64 70"	1.35	56	3.42	Yes		Yes* Yes**	

* A "qualifying" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "conforms" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). (*see Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

+Post-bronchodilator.

For a miner of the claimant's height of 70.5 inches, § 718.204(c)(1) requires an FEV₁ equal to or less than 2.03 for a male 64 years of age.⁸ If such an FEV₁ is shown, there must be in addition, an FVC equal to or less than 2.59 or an MVV equal to or less than 81; or a ratio equal to or less than

⁸ The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 43 F.3d 3 (4th Cir. 1995). I find the miner is 70.5" here, his average reported height.

55% when the results of the FEV1 test are divided by the results of the FVC test.

C. Arterial Blood Gas Studies⁹

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O₂) compared to carbon dioxide (CO₂) in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex.#	Physician	pCO ₂	PO ₂	Qualify	Physician Impression
4-8-77 DX 39	Beckley Hospital	31	75	No	
8-16-78 DX 39	Beckley Hospital	30	82	No	
6-2-80 DX 39	Beckley Hospital	34	94	No	
6-24-80 DX 39	Beckley Hospital	32	78	No	
7-29-82 DX 39	Beckley Hospital	27.8	87.7	No	
8-31-94 DX 39	Daniel	38.2 +42.2	75 +68	No No	
5-22-96 DX 40	Rasmussen	40 +43	71 +69	No No	
2-19-97 DX 19, 40	Castle	41.7 +44.4	69 +72.4	No No	
3-23-00 DX 12	Gaziano	41 +46	69 +74	No No	

⁹ 20 C.F.R. § 718.105 sets the quality standards for blood gas studies. 20 C.F.R. § 718.204(c) permits the use of such studies to establish “total disability.” It provides: In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (c)(1), (2), (3), (4), or (5) of this section shall establish a miner’s total disability: . . .

(2) Arterial blood gas tests show the values listed in Appendix C to this part . . .

Date Ex.#	Physician	pCO ₂	PO ₂	Qualify	Physician Impression
3-29-00 DX 12	Zaldivar	43 +48	61 +68	No No	

+ Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4).

The medical report of Dr. John M. Daniel is dated August 31, 1994 and is found at DX 39. Dr. Daniel is Board-Certified in Family Practice. Dr. Daniel conducted an examination of the claimant on behalf of the Department of Labor. He noted claimant's employment history and family medical history. The claimant had a history of frequent colds and attacks of wheezing. The claimant had been smoking one pack of cigarettes per day from 1953 (41 pack years). The claimant's chief complaints were sputum production, wheezing, dyspnea, and cough. Physical examination was unremarkable. Dr. Daniel reviewed the results of a chest x-ray, vent study, arterial blood gas, and an EKG that were performed on August 31, 1994 in conjunction with the medical evaluation. Dr. Daniel diagnosed claimant as having chronic obstructive pulmonary disease ("COPD") on the basis of an abnormal vent study, a history of smoking, and a history of chronic productive cough. He attributed the cause of the COPD to cigarette smoking. Dr. Daniel added that there was evidence of a moderate pulmonary impairment and that the claimant would be unable to perform heavy manual labor. This impairment was due to the COPD.

The medical report of Dr. D.L. Rasmussen is dated May 22, 1996 and is found at DX 40. A separate narrative summary of the examination prepared by Dr. Rasmussen was also attached and was dated June 16, 1996. Dr. Rasmussen conducted an examination on behalf of the Department of Labor. Dr. Rasmussen reviewed the claimant's employment history and noted that his last job as a foreman required considerable heavy manual labor. He reviewed the claimant's family medical history and noted an individual history of frequent colds, attacks of wheezing, and arthritis. It was noted that the claimant had a cardiac catheterization in the early 1980s. The claimant reported that he smoked 1 ½ packs of cigarettes per day from 1954, but now smoked ½ pack per day (63 pack year). The claimant's chief complaints were sputum production, wheezing, dyspnea, cough, chest pain, and orthopnea. Physical examination revealed minimal to moderately reduced breath sounds and a prolongation of expiratory phase with forced expirations. A chest x-ray, vent study, arterial blood gas and EKG were performed on 5-22-96 as part of the medical evaluation. Dr. Rasmussen diagnosed the claimant as having coal workers' pneumoconiosis due to coal dust exposure based on 17 years of coal mine employment and x-ray evidence of pneumoconiosis and COPD – emphysema due to coal mine dust exposure and cigarette smoking based on chronic airflow impairment and decreased SBDLCO. Dr. Rasmussen opined that the

claimant had a moderately severe loss of lung function and that he was totally disabled from resuming his last coal mine job. He also noted that the coal mine dust exposure was at least a major contributing factor to the impairment.

The medical note of Dr. Rasmussen is dated April 3, 1997 and appears at DX 40. Dr. Rasmussen reviewed the x-ray interpretation of Dr. Francke who was a B-reader. He also noted that the claimant had a relatively short history of coal dust exposure. Dr. Rasmussen concluded that in view of Dr. Francke's B-reading (0/0) of no pneumoconiosis, he was unable to make a positive diagnosis of pneumoconiosis.

The deposition of Dr. Rasmussen was taken on January 29, 2002 and is appears at EX 8. Dr. Rasmussen is Board-Certified in Internal Medicine and is now a B-reader of chest x-rays. He noted that the claimant had a very significant smoking history (60 pack years) that placed him at risk to develop chronic obstructive lung disease, including bronchitis and emphysema, and cardiovascular disease and cancer. Dr. Rasmussen stated that the claimant had performed, as foreman, heavy manual labor at the face of the mine. He noted that the claimant had a significant change in his vent capacity over the years but could not say for certain that cigarette smoking was indeed the whole cause of his loss of function. However, he opined that if the claimant did not smoke that he probably could go back to doing heavy manual labor. On cross-examination, Dr. Rasmussen agreed that the claimant had COPD based on vent studies. He added that there was no exact way to measure the individual contribution of coal mine dust and cigarette smoking to the claimant's overall pulmonary condition. He stated that the only correct medical diagnosis would include both exposures as factors. Dr. Rasmussen stated that it was not reasonable to attribute all of the claimant's impairment to smoking. He concluded that the claimant was totally disabled from performing his last coal mine employment.

The medical report of Dr. James R. Castle is dated April 9, 1997 and appears at DX 19. Dr. Castle is Board-Certified in Internal Medicine and Pulmonary Disease. Dr. Castle examined the claimant at the request of the employer. The claimant complained of shortness of breath and cough productive of sputum on a daily basis for at least 15 to 20 years. He also reported wheezing for a number of years. The claimant reported that he started smoking when he was 18 years old and was currently smoking about ½ pack of cigarettes per day. Dr. Castle noted that the claimant had a 40- pack year smoking history. Dr. Castle reviewed the claimant's past medical history, family history and occupational history noting 17 ½ years of coal mine employment. Physical examination revealed bilateral scattered rhonchi that improved after coughing. Dr. Castle reviewed a chest x-ray, vent study, arterial blood gas and an EKG. He also reviewed the results of a carboxyhemoglobin that was significantly elevated at 7.6%. Based on the results of his own examination, Dr. Castle concluded that the claimant had no evidence of CWP by physical examination, radiographic evaluation, physiologic testing and arterial blood gases. He concluded that the claimant did suffer from COPD induced by tobacco smoke, chronic bronchitis induced by tobacco smoke, moderate obstructive airways disease secondary to tobacco smoke induced COPD, elevated carboxyhemoglobin level consistent with smoking in excess of pack of cigarettes per day, and a history of nerve disorder. Dr. Castle then reviewed additional

medical evidence. Dr. Castle noted that in 1983, when he last worked in the mines, the claimant did not have significant changes in his vent studies. He added that in the absence of coal dust exposure, the changes over the last 14 years would have been associated with tobacco abuse. He again concluded that the claimant did not have CWP. He did note that the claimant had a moderate obstructive airways disease that was tobacco smoke induced. The claimant did not have evidence of a mixed irreversible obstructive and restrictive impairment such as would be seen with CWP. Dr. Castle concluded that the claimant may be disabled due to his respiratory impairment but that he did not have any respiratory impairment related to CWP or his coal mining employment. The claimant did not suffer from any chronic lung disease that has been caused by, contributed to, or substantially aggravated by coal mine dust exposure. He added that even if one were to assume the claimant had radiographic evidence of simple CWP, he would still not be disabled by that process.

The medical report of Dr. John M. Daniel is dated September 22, 1997 and appears at DX 19, 40. In this supplemental report, Dr. Daniel answered a number of questions that were submitted to him by the employer regarding the examination of the claimant in August of 1994. Dr. Daniel concluded that the claimant showed evidence of a moderate to severe respiratory impairment as a result of chronic obstructive lung disease totally due to cigarette smoking. Dr. Daniel opined that the claimant probably did not retain the capacity to perform his last coal mine employment unless his job was strictly supervisory. Dr. Daniel concluded that the claimant did not suffer from pneumoconiosis but did suffer from a respiratory impairment secondary to smoking.

The medical report of Dr. Gregory J. Fino is dated September 23, 1997 and appears at DX 21, 40. Dr. Fino is Board-Certified in Internal Medicine and Pulmonary Disease. He conducted a medical record review at the request of the employer. Based on his review of the medical evidence in the record, Dr. Fino concluded that there was insufficient objective medical evidence to justify a diagnosis of simple, CWP. It was also his opinion that the claimant did not suffer from an occupationally acquired pulmonary condition. Dr. Fino opined there was a moderate obstructive ventilatory abnormality present that was related to cigarette smoking. Dr. Fino stated that the claimant would be unable to return to last mining job or a job requiring similar effort. He added that the claimant would be as disabled as if he had never stepped foot in the coal mine. Dr. Fino added that his opinions regarding the claimant's disability would not change even if the claimant were found to have pneumoconiosis.

The medical report of Dr. W.K.C. Morgan is dated October 17, 1997 and appears at DX 19, 40. Dr. Morgan conducted a medical records review on behalf of the employer. Dr. Morgan concluded that there was insufficient evidence to make a diagnosis of CWP. The claimant did have a moderate pulmonary impairment that was related to cigarette smoking and not to CWP. He added that the claimant was probably permanently disabled on account of his anxiety and other problems. Dr. Morgan added that the claimant maintained sufficient respiratory reserve to do his regular coal mine work, albeit with some difficulty. This disability was not related to coal dust exposure. Even assuming that claimant did have CWP, Dr. Morgan opined that the claimant's

respiratory impairment was due to cigarette smoke induced emphysema and small airways disease.

The medical report of Dr. A.C. Cohen is dated October 28, 1997 and appears at DX 40. Dr. Cohen is Board-Certified in Internal Medicine and Pulmonary Disease. Dr. Cohen conducted a medical record review at the request of the claimant. He noted a smoking history of 1 ½ packs of cigarettes per day from 1954 to recently when he cut back to ½ pack per day. Dr. Cohen also noted an occupational history of 17.5 years of coal mine employment. Dr. Cohen concluded that the claimant did have coal workers' pneumoconiosis based on significant exposure to coal dust, symptoms of chronic lung disease dating from 1960s, physical examinations that showed signs of chronic lung disease, vent studies that showed moderate to severe obstructive lung disease, arterial blood gases that showed hypoxemia, and some x-ray evidence that was positive for pneumoconiosis. Dr. Cohen opined that the claimant was totally disabled from performing his last coal mine employment due to his exposure to coal dust and tobacco smoke. Dr. Cohen stated that obstructive airways disease can be caused as a result from coal mine dust exposure. Moreover, Dr. Cohen asserted that simple CWP, complicated CWP, and obstructive lung disease caused by coal dust have all been shown to progress after exposure ceases. Dr. Cohen concluded that the claimant's 17.5 years of coal dust exposure and 43 pack years of smoking were significantly contributory to the development of his severe obstructive lung disease.

The deposition of Dr. Castle was taken on November 5, 1997 and appears at DX-40. Dr. Castle reviewed additional medical evidence. Dr. Castle opined that the claimant did not have the pulmonary capacity to perform his last coal mine employment due to his tobacco smoke induced COPD. Dr. Castle opined that the claimant did not have medical or legal pneumoconiosis. He disagreed with Dr. Cohen's statement in his report that suggested that he (Dr. Castle) did not believe that CWP could cause obstructive airways disease. Dr. Castle testified that CWP could cause an obstructive defect. Dr. Castle noted that when the claimant left the mines he had essentially normal vent studies, subsequently, the claimant continued to smoke heavily. The remainder of Dr. Castle's testimony was basically a reiteration of the findings contained within his written report.

The medical report of Dr. Gaziano is dated March 23, 2000 and appears at DX 11. Dr. Gaziano examined the claimant on behalf of the Department of Labor. Dr. Gaziano noted 17 ½ years of coal mine employment and reviewed the claimant's family medical history. The claimant reported having attacks of wheezing and arthritis. The claimant indicated that he had stopped smoking at age 62. Previously he had smoked one (1) to 1 ½ packs of cigarettes per day from the age of 18 (44 to 66 pack years). The claimant's chief complaints were sputum production, dyspnea, cough, chest pain, and orthopnea. Physical examination was unremarkable. A chest x-ray, vent study, and arterial blood gas were performed on 3-23-00 in conjunction with the examination. Dr. Gaziano diagnosed the claimant as having coal workers' pneumoconiosis due to coal mining. He added that the claimant would be unable to work in the mines due to his moderately severe impairment.

The medical report of Dr. George L. Zaldivar is dated May 1, 2000 and appears at DX 24.

Dr. Zaldivar examined the claimant on 3-29-00 at the request of the employer. Moreover, he reviewed additional medical records. Dr. Zaldivar noted the claimant's chief complaint was shortness of breath. He reviewed the claimant's occupational history and noted 17 ½ years of coal mine employment. Physical examination revealed expiratory wheezes in all lung fields. Dr. Zaldivar reviewed the results of a vent study, chest x-ray, arterial blood gas and EKG that were performed in conjunction with his evaluation. Dr. Zaldivar noted that the claimant had a very high carboxyhemoglobin suggesting a current smoker of over a pack of cigarettes per day. He concluded that there was no evidence of CWP or any dust disease of the lungs. Dr. Zaldivar acknowledged there was a pulmonary impairment present sufficient to prevent the claimant from performing his last coal mine employment. This pulmonary impairment was entirely due to emphysema caused by the claimant's smoking habit. He added the claimant had bullous emphysema radiographically which is a typical finding of smokers. Dr. Zaldivar opined that even if the claimant were found to have CWP, his opinion regarding the cause of the pulmonary impairment would not change.

The supplemental medical report of Dr. Zaldivar is dated July 18, 2000 and appears at DX 29. After reviewing additional medical evidence Dr. Zaldivar concluded that his opinion remained unchanged. He noted that at the time of the 3-29-00 examination, the claimant was still smoking. Although the claimant stated he had quit smoking two months before, his carboxyhemoglobin was 9.9, which was that of a smoker of over a pack of cigarettes per day. He added that such a smoking habit was sufficient to have caused severe emphysema, which was the disease from which the claimant suffered. Dr. Zaldivar noted that the dust burden of the claimant's lungs must be very low or practically nonexistent. Coupling the smoking habit with the meager evidence of dust retention in the lungs, Dr. Zaldivar concluded that the emphysema was due to smoking and not to his occupation.

The deposition of Dr. Zaldivar was taken on March 19, 2002 and appears at EX 11. Dr. Zaldivar is Board-Certified in Internal Medicine, Pulmonary Medicine, Critical Care Medicine, and Sleep Disorders and is a B-reader of chest x-rays. He agreed that coal dust exposure could cause an obstructive defect. Dr. Zaldivar considered the following in concluding that the claimant did not have a coal mine induced lung disease: (1) a very high carboxyhemoglobin of 9.9% indicating the claimant was still smoking at a time the claimant maintained that he had stopped smoking, (2) chest x-ray in determining the dust burden of the lungs, and (3) blood gases. He stated that it was unusual for individuals to have some progression of their coal mine dust induced lung disease after they cease exposure. Dr. Zaldivar noted that the pattern of impairment seen in this case was very much consistent with someone who developed smoking induced emphysema. He reviewed a CT scan that was taken on December 6, 2001. He found vascular markings throughout the lungs that were the result of destruction of lung tissue by emphysema. There was no evidence of dust retention by CT scan. The bullae seen was typical of emphysema for smokers.

The medical report of Dr. Thomas M. Jarboe is dated February 22, 2001 and appears at EX 4. Dr. Jarboe is Board-Certified in Internal Medicine and Pulmonary Disease and is a B-

reader of chest x-rays. Dr. Jarboe conducted a medical record review at the request of the employer. Dr. Jarboe concluded that there was insufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis. He opined that the radiologic evidence did not support such a finding and that the physiological data did not support a diagnosis of a dust induced lung disease. He stated the claimant's emphysema was caused by cigarette smoking. Dr. Jarboe concluded that the claimant had a moderately severe respiratory impairment due to cigarette smoking with resulting pulmonary emphysema and not due to coal dust inhalation. He opined that the claimant would be totally and permanently disabled from a pulmonary standpoint from performing his last coal mine employment. Dr. Jarboe indicated that the claimant's disability was caused by a long history of heavy cigarette smoking. He found no disease of the respiratory system that had been caused by or substantially contributed to by the inhalation of coal dust or the presence of pneumoconiosis.

The medial report of Dr. Fino is dated February 26, 2001 and appears at EX 3. Dr. Fino conducted a medical record review at the request of the employer. Dr. Fino reviewed additional medical evidence and concluded that the claimant suffered from chronic airway obstruction related to cigarette smoking. Dr. Fino concluded the claimant did have a disabling respiratory impairment due to chronic airway obstruction related to cigarette smoking. He opined that coal workers' pneumoconiosis was not present but even if CWP were present, it played no more than a negligible role in his total impairment and disability. Dr. Fino added that CWP was not a significant contributing factor to the claimant's disability.

The supplemental medical report of Dr. Daniel is dated March 5, 2001 and appears at EX 5. In his report, Dr. Daniel addressed several questions that had been posed by the employer. Dr. Daniel stated that there was no objective evidence that the claimant had pneumoconiosis. He added there was evidence that the claimant suffered from a moderate respiratory impairment secondary to a 40- pack year history of smoking cigarettes. The claimant had evidence of mild bullous emphysema on x-ray but that this was secondary to smoking. Assuming that the claimant's position as foreman was supervisory in nature, the degree of impairment present would not prevent the claimant from performing his last coal mine employment. Dr. Daniel noted that if pneumoconiosis was found to be present, it would be very mild and would not change his opinion.

The medical report of Dr. Castle is dated March 13, 2001 and appears at EX 6. At the request of the employer, Dr. Castle reviewed additional medical records. After a thorough review of the evidence, including the medical histories, physical examinations, radiographic reports, pulmonary function tests, and arterial blood gases, Dr. Castle stated that the claimant does not suffer from CWP. He noted that the claimant had in excess of a 44-pack year smoking history. It continued to be his opinion that the claimant was permanently and totally disabled as a result of moderately severe tobacco smoke induced chronic airway obstruction due to chronic bronchitis and emphysema. Dr. Castle opined that the claimant did not suffer from a chronic disabling respiratory disease caused by, contributed to, or aggravated by his coal mine dust exposure. Dr. Castle added that if pneumoconiosis was found to be present, his opinions regarding a lack of disability due to that process would remain unchanged based on a lack of physiologic or other

abnormalities noted to cause impairment related to this process.

The medical report of Dr. Morgan is dated May 2, 2001 and appears at EX 7. At the request of the employer Dr. Morgan reviewed additional medical records. He concluded that the claimant suffered from a significant pulmonary impairment that was obstructive in nature. The obstruction is appreciably worse now than it was in 1997 and that this was obviously related to cigarette smoking since the claimant has had no coal mine dust exposure for the last 20 years. Dr. Morgan added that while it was possible for CWP to progress following cessation of exposure to coal dust, it was unreasonable to expect that the decline would be slow and minor to begin with, then suddenly speed up later in life. Dr. Morgan concluded that the claimant was totally and permanently disabled as a result of his COPD. There was no radiographic evidence of CWP. In conclusion, Dr. Morgan stated that there was no evidence that coal dust played any role whatsoever in the induction of the claimant's respiratory impairment.

The deposition of Dr. Morgan was taken on March 13, 2002 and appears at EX 10. Dr. Morgan received his medical training and education in England where he was certified in internal medicine and pulmonary disease. He is also a B-reader of chest x-rays. He indicated that a carboxyhemoglobin result could be elevated 1 to 2% if exposed to somebody sitting next to you who was smoking. He opined that a carboxyhemoglobin of 9.9% indicated a 1 ½ to 2 pack per day smoking habit. He disagreed with Dr. Cohen's interpretation of some of the studies he cited in his report. Dr. Morgan stated that the claimant did not have radiographic evidence of CWP and did not have any chronic coal mine induced lung disease arising out of coal mine employment. He did not believe that coal mine dust was a contributing factor because the claimant's condition had worsened over a period of time when he was not exposed to coal dust. He noted that changes could occur in the lungs after exposure ceased but that it cleared within a year. Dr. Morgan opined that the claimant would not have a disabling pulmonary condition if he had not smoked cigarettes. He stated that it would be very unusual to have COPD arising from respirable coal mine dust and causing significant pulmonary impairment with a negative chest x-ray.

The medical report of Dr. Dan Doyle is dated February 27, 2002 and appears at CX 13. Dr. Doyle indicated that he was the claimant's treating physician. He had been treating the claimant since 8-21-97. He saw the claimant 10 times over a 4 ½ year period for shortness of breath. His most recent examination of the claimant was on 12-5-01 for continuing shortness of breath. He also noted that the claimant had been hospitalized for COPD. He added that he had prescribed continuous oxygen for the claimant on 7-2001 based on a blood gas study. Physical examination of the claimant on 12-5-01 revealed an increased AP diameter, decreased breath sounds, and expiratory rhonchi over all lung fields. Dr. Doyle reviewed the results of various x-rays and pulmonary function testing conducted over the last 15 years that showed a persistent severe or moderately severe obstructive pattern. Dr. Doyle stated that Drs. Morgan, Castle, Daniel and Fino found no radiographic evidence of pneumoconiosis (medical pneumoconiosis) but ignored the possibility of COPD attributable to coal dust (legal pneumoconiosis) as a possible diagnosis. For this reason he found their respective reports unconvincing. Dr. Doyle opined that the claimant had coal workers' pneumoconiosis based on several positive B-readings,

occupational history of 17 years of coal mine employment, and the presence of a severe obstructive pulmonary disease attributable at least in part to his coal dust exposure and smoking. Dr. Doyle stated that he knew of no scientific method of relative distribution. He could not see how any clinician could exclude 17 years of exposure to dusty conditions as a contributing factor to his pulmonary disease. In his opinion the claimant was totally disabled due to his pulmonary impairment since his first examination of 8-21-97. He added that the claimant's condition had steadily progressed and worsened over the last 2 ½ years.

The deposition of Dr. Wheeler was taken on February 27, 2002 and appears at EX 12. Dr. Wheeler is a Board-Certified Radiologist and B-reader. He stated that if there is uncertainty in reading x-rays the CT scan is used to resolve the discrepancy. He reviewed the CT scan of 12-12-01 and noted there was no evidence of pneumoconiosis. Dr. Wheeler stated that the CT scan was the best way to determine the presence or absence of any sort of interstitial disease. He stated there was no reason to suspect that the claimant had silico-tuberculosis. He added that the granulomatous lesion differed in appearance to a CWP macule in that it was calcified indicating a healed infection.

Miscellaneous Medical Records

As part of the record, are the Tuberculosis Clinic records that are dated October 17, 1986 and are found at DX 40. The claimant had a positive tine skin test for TB as part of his application for school employment. It was noted that he had no symptoms of the disease. The diagnosis was tuberculosis infection without disease, chemotherapy was not started because of age, and he was to be checked at 4-month intervals in the clinic and by x-ray. After one year he was discharged from the clinic since he completed one year of observation without evidence of tuberculosis.

Also of record are the medical records from the University of Virginia when the claimant was admitted on 3-27-83 for chronic lung disease, cardiac catheterization, and hyperventilation. (DX 40). The claimant was discharged on 3-31-83.

On November 11, 1986, the OP Board found that the claimant had occupational pneumoconiosis with 25% pulmonary function impairment. (DX 6, 29, 40).

As part of the record, are the progress notes from the Cleveland Clinic dated 10-15-98 to 11-20-98. (DX 40). It was noted that the claimant suffered from chronic obstructive pulmonary disease and chronic bronchitis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

B. Modification

Section 22 of the Longshore and Harbor Workers' Compensation Act provides in part that:

Upon his own initiative, or upon the application of any party ... on the ground of a change in conditions or because of a mistake in a determination of fact ... the [fact-finder] may, at any time ... prior to one year after the rejection of a claim, review a compensation case ...

33 U.S.C. § 922, as incorporated by 30 U.S.C. § 932(a) and implemented by 20 C.F.R. § 725.310.

Section 22 provides the sole avenue for changing otherwise final decisions on a claim. *Metropolitan Stevedore Co. v. Rambo*, 515 U.S. 291, 295 (1995)(*Rambo I*); *Kinlaw v. Stevens Shipping and Terminal Co.*, 33 BRBS 68 (1999), *aff'd.*, No. 99-1954, 2000 U.S.App. LEXIS 31354 (4th Cir. April 5, 2000).

Judicial authority requires a broad reading of Section 22, and neither the wording of the statute nor its legislative history supports a "narrowly technical and impractical construction." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 255 (1971); *Branham v. BethEnergy Mines, Inc.*, 20 B.L.R. 1-27, 1-31-33 (1996). Given its liberal application, it is clear that the petition seeking modification need not allege any specific ground or relief. *See Keating v. Director, OWCP*, 71 F.3d 1118, 1123, 20 BLR 2-53 (3d Cir. 1995); *Jessee v. Director, OWCP*, 5 F.3d 723, 18 B.L.R. 2-26 (4th Cir. 1993); *accord Consolidation Coal Co. v. Worrell*, 27 F.3d 227, 18 B.L.R. 2-290 (6th Cir. 1994); *see generally Fireman's Fund Insurance Co. v. Bergeron*, 493 F.2d 545, 547 (5th Cir. 1974); H.Rep.No. 1244, 73d Cong., 2d Sess. 4 (1934).

While the modification procedure, and the adjudicator's authority to reopen the claim, is "easily invoked," *Betty B Coal Co. v. Director, OWCP*, 194 F.3d 491, 497, 22 BLR 2-1 (4th Cir. 1999) (*Stanley*), the decision whether to grant modification on the basis of a mistake in determination of fact is committed to the adjudicator's discretion. *See Kinlaw*, 2000 U.S.App.

LEXIS 31354 at *8-10, *aff'g* 33 BRBS 68 (1999); *see also* *Duran v. Interport Maintenance Co.*, 27 BRBS 8,14 (1993) (Board reviews Section 22 findings under abuse of discretion standard). This is not to say that an administrative law judge or district director may simply deny a petition for modification on a whim. To do so would constitute an abuse of discretion as being arbitrary and capricious and unwarranted by the record.

The adjudicator must examine the record as a whole, *see Keating*, 71 F.3d at 1123, 20 B.L.R. 2-53, render findings which must be supported by substantial evidence, and articulate a rationale for its decision, even though the decision on whether to reopen a claim is committed to its discretion. Indeed, the adjudicator “has the authority, *if not the duty*, to reconsider all the evidence for any mistake of fact or change in condition,” *Worrell*, 27 F.3d at 230, 18 BLR 2-290 (emphasis added); *see Jessee*, 5 F.3d at 726, 18 BLR 2-26 (deputy commissioner “must” review request for modification), by examining “wholly new evidence, cumulative evidence, or merely [by] further reflection on the evidence initially submitted.” Moreover, if the evidence establishes that a claimant’s condition has worsened, modification will be appropriate because a claimant “should receive his benefits if and when he becomes entitled to them.” *Stanley*, 194 F.3d at 500 n.4, 22 B.L.R. 2-1.

In every instance, the party who seeks to reopen a claim on modification bears the burden of proof. *Metropolitan Stevedore Co. v. Rambo*, 521 U.S. 121, 138-39 (1997) (*Rambo II*); *Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 736, 17 B.L.R. 2-64 (3d Cir. 1993), *aff'd* 512 U.S. 267 (1994).

With this in mind, I turn to the merits of Claimant’s Request for Modification. While this decision is based on a *de novo* review and consideration of the administrative record as a whole, not all of the evidence that has been introduced prior to the instant request for modification, and has been set

forth in the prior Decisions, may again be listed except as required for an analysis of the current request for modification. *See generally Wheeler v. Apfel*, 224 F.3d 891, 895 n.3 (8th Cir. 2000).

Further, given the progressive nature of pneumoconiosis, *see Eastern Associated Coal Corporation v. Director, OWCP*, 220 F.3d 250, 258 (4th Cir. 2000), the more recent evidence with respect to the nature and extent of Claimant’s pulmonary or respiratory disability would be the more probative of his condition at the time of the hearing. *See Cooley v. Island Creek Coal Co.*, 845 F.2d 622, 11 B.L.R. 2-147 (6th Cir. 1988); *see also Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985). Having reviewed the patient record, I do not find a mistake of fact or change in condition. My analysis follows.

C. Existence of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as a “a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out

of coal mine employment.”¹⁰ The definition is not confined to “coal workers’ pneumoconiosis,” but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.¹¹

20 C.F.R. § 718.201. The term “arising out of coal mine employment” is defined as including “any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.”

“ . . . [T]his broad definition ‘effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.’” *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing*, *Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980). Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

The claimant has the burden of proving the existence of pneumoconiosis by any one of

¹⁰ Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3^d Cir. 1995) at 314-315.

¹¹ Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, “pneumoconiosis” means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or “clinical”, pneumoconiosis and statutory, or “legal”, pneumoconiosis.

(1) Clinical Pneumoconiosis. “Clinical pneumoconiosis” consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers’ pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. “Legal pneumoconiosis” includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease “arising out of coal mine employment” includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, “pneumoconiosis” is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure. (Emphasis added).

four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrefutable presumption for “complicated pneumoconiosis” found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.¹² 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers’ pneumoconiosis. This is contrary to the Board’s view that an administrative law judge may weigh the evidence under each subsection separately, *i.e.* x-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit’s decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant has not established pneumoconiosis pursuant to subsection 718.202(a)(2) by autopsy or biopsy evidence. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable. There is no evidence of complicated pneumoconiosis in this case.

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence.¹³ 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). “[W]here two or more x-ray reports are in conflict, in evaluating such x-ray reports, consideration shall be given

¹² In accordance with the Board’s guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel*, 21 B.L.R. 1-182 (1999) citing *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are “documented” (medical), *i.e.*, the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and “reasoned” since the documentation supports the doctor’s assessment of the miner’s health.

¹³ “There are twelve levels of profusion classification for the radiographic interpretation of simple pneumoconiosis. 2/3 is the fourth highest profusion and 3/2 the third. See N. LeRoy Lapp, “A Lawyer’s Medical Guide to Black Lung Litigation,” 83 W. Va. Law Review 721, 729-731 (1981).” Cited in *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1359, n. 1.

to the radiological qualifications of the physicians interpreting such x-rays.” *Id.*; *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985).”(Emphasis added). (Fact one is board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-Certified Radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985).

While a judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). The ALJ must rely on the evidence which he deems to be most probative, even where it is contrary to the numerical majority. *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984).

In addition, the Fourth Circuit holds that a judge may afford more weight to recent medical evidence. *Adkins v. Director, OWCP*, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). It is rational to credit more recent evidence, solely on the basis of recency, only if it shows the miner’s condition has progressed or worsened. The court reasoned that, because it is impossible to reconcile conflicting evidence based on its chronological order if the evidence shows that a miner’s condition has improved, inasmuch as pneumoconiosis is a progressive disease and claimants cannot get better, “[e]ither the earlier or the later result must be wrong, and it is just as likely that the later evidence is faulty as the as the earlier. . .” *See also, Thorn v. Itmann Coal Co.*, 3 F.3d 713, 18 B.L.R. 2-16 (4th Cir. 1993).

Of the submitted evidence, there are seventy-nine (79) interpretations of sixteen (16) x-rays and one (1) CT Scan in the record. (see Appendix A). Of the seventy-nine (79) interpretations, seven (7) were deemed unreadable, fifty (50) were negative (a profusion of 0/1 or 0/0 in the ILO classification) and twenty-two (22) were positive for pneumoconiosis (a profusion of 1/0 or higher in the ILO Classification). There are thirty-four (34) negative interpretations that have been rendered by Board-Certified Radiologists and B-readers. Whereas there are sixteen (16) positive interpretations rendered by dually qualified physicians. The record contains an interpretation by Dr. Miller, whose qualifications are unknown, of the most recent CT scan from 12-6-01. Dr. Miller found no pulmonary mass or nodule. Moreover, Dr. Wheeler, who is a BCR-B, at his deposition, reviewed the 12-6-01 CT scan and found no evidence of pneumoconiosis.¹⁴

¹⁴ Even in light of the adverse inference that was imposed against the employer by Order of February 1, 2002, i.e. that the claimant could have submitted three positive BCR-B interpretations of the 3-29-00 x-ray, the vast majority of the negative x-rays still outweigh the positive, and the outcome would remain the same. (see Order dated February 1, 2002).

I accord more weight to the interpretations of the dually qualified Board-certified radiologists and B-readers. As noted, the vast majority of the interpretations by dually qualified physicians were negative for pneumoconiosis.

Accordingly, as the overwhelming majority of the interpretations of the dually qualified physicians are negative for pneumoconiosis, I find that Claimant has failed to prove by the preponderance of the evidence the existence of pneumoconiosis by x-ray evidence.

Additionally, a determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a). Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contraindicates it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

In the instant matter, ten physicians submitted reports regarding Mr. Marcum's medical condition. Drs. Daniel, Castle, Fino, Morgan, Zaldivar, and Jarboe found no evidence of pneumoconiosis. While Drs. Rasmussen, Cohen, Gaziano, and Doyle concluded that Mr. Marcum had coal workers pneumoconiosis.

I accord little weight to the opinion of Dr. Cohen who concluded that the claimant had severe obstructive lung disease due to both his coal mine employment and smoking. I find that Dr. Cohen's report is not credible. First, he based his opinion on a smoking history of 43 pack years when it was at least 66 pack years.¹⁵ Moreover, Dr. Cohen failed to address whether the claimant's obstructive lung disease could have resulted solely from his cigarette smoking, a history that was much more significant than his 17 years of coal mine employment.

Likewise, I accord Dr. Rasmussen's opinion little weight for the following reasons. First, Dr. Rasmussen in his 1996 report found radiographic evidence of CWP, then in 1997 he retracted his diagnosis of pneumoconiosis after reviewing a negative BCR-B reading by Dr. Francke. Then at his deposition in 2002, Dr. Rasmussen stated that the claimant suffered from COPD due to cigarette smoking and coal mine dust exposure. However, Dr. Rasmussen then stated that if the claimant had never smoked, he would have the pulmonary capacity to perform heavy labor suggesting that the contribution of coal mine dust exposure to the claimant's pulmonary condition

¹⁵ Perhaps if Dr. Cohen had an accurate picture of the claimant's smoking habit, his opinion regarding the contribution of inhalation of coal dust to the claimant's current condition would have changed.

was minimal. Accordingly, I find Dr. Rasmussen's opinion to be equivocal, inconsistent, and unreasoned given his contradictory statements in his two written reports and at his deposition. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984), *See Brazzale v. Director, OWCP*, 803 F.2d 934 (8th Cir. 1986).

Additionally, I accord less weight to the opinion of Dr. Gaziano who based his diagnosis of pneumoconiosis presumably on a chest x-ray that he read as positive (1/0) for pneumoconiosis.¹⁶ As noted previously the overwhelming majority of the more credible x-ray interpretations were negative for pneumoconiosis. Because Dr. Gaziano provided no other explanation for his finding of pneumoconiosis, I find his opinion is not well-reasoned and not well-documented and I accord his opinion less weight.

Dr. Doyle, claimant's treating physician, diagnosed the claimant as having coal workers' pneumoconiosis and obstructive pulmonary disease due to coal dust exposure and smoking. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole. § 718.104(d)(5). Although Dr. Doyle was the claimant's treating physician for many years, I find that his opinion should not be given controlling weight in this case. Dr. Doyle is Board-Certified in Family Medicine but does not have a certification in Internal Medicine and/or Pulmonary Disease as does Drs. Castle, Fino, Morgan (certification in England), Zaldivar, and Jarboe. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Moreover Dr. Doyle's diagnosis of (medical) pneumoconiosis appears premised on positive chest x-ray interpretations. As noted several times previously, the vast majority of the more credible x-ray interpretations were negative for pneumoconiosis. In addition, the most recent CT scan read by Dr. Wheeler, a Board-Certified Radiologist and B-reader, was negative for pneumoconiosis.

Dr. Doyle incorrectly criticized Drs. Castle, Morgan, Zaldivar, and Fino for excluding the presence of coal mine dust induced lung disease solely on negative x-rays. Dr. Doyle included coal dust exposure as a cause of the claimant's COPD (legal pneumoconiosis) simply because he knew of no scientific or logical grounds how any clinician could "say that this retired miner, who spent 17 years underground in dusty conditions, has no pulmonary disease due to his occupational exposure. The contribution of coal dust exposure simply cannot be excluded as a contributing factor because of the presence of a substantial cigarette smoking history." I find that this logic is fundamentally flawed. The record shows that at the time the claimant left the mines in 1982, his pulmonary function studies were relatively normal. Subsequently, the claimant's exposure to coal mine dust ceased but he continued to smoke heavily over, at least, the next 15 years. In fact the record arguably supports a finding that the claimant's cigarette smoking was three to four times

¹⁶ Dr. Gaziano does not specifically state the basis for his finding of coal worker's pneumoconiosis in his report but it can be reasonably inferred that it was based at least in part on his positive x-ray reading.

more significant than his 17 years of coal mine work in regard to his development of impaired lung function. (see Dr. Cohen's report whereby Dr. Cohen cites with approval medical literature equating one year of coal dust exposure to one pack year of cigarette smoking in their effects on lung function). Since cigarette smoking, alone, is known to cause severe obstructive lung disease, Dr. Doyle's failure to explain why that might not be the case here is a serious flaw. For these reasons, I find that the report of Dr. Doyle is not well-reasoned and is not well-documented. Accordingly, I accord less weight to the opinion of Dr. Doyle.

Moreover, I find that the findings of Drs. Rasmussen, Cohen, Gaziano, and Doyle have been contradicted by the medical opinions of Dr. Daniel, Castle, Morgan, Jarboe, Zaldivar, and Fino. Drs. Jarboe, Zaldivar and Fino are B-readers and are Board-Certified in Internal Medicine and Pulmonary Diseases. Drs. Castle and Morgan (in England) are Board-Certified in Internal Medicine and Pulmonary Diseases. Dr. Daniel is Board-Certified in Family Medicine. All six physicians concluded that there was no evidence of coal workers' pneumoconiosis. After weighing the qualifications of the physicians, I give more weight to the opinions of Drs. Daniel, Castle, Morgan, Jarboe, Zaldivar, and Fino. *Burns, supra*.

Based upon the radiographic evidence and medical opinion evidence of record, I find that Mr. Marcum has failed to establish, by a preponderance of the evidence, that he has coal workers' pneumoconiosis, as required by the Act and Regulations.

D. Cause of pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since I have found that Mr. Marcum had at least seventeen years of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of pneumoconiosis has not been proven this issue is moot.

E. Cause of total disability¹⁷

¹⁷ *Billings v. Harlan #4 Coal Co.*, ___ B.L.R. ___, BRB No. 94-3721 (June 19, 1997). The Board has held that

The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words “material” and “materially”, results in “evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner’s total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability.” 65 Fed. Reg. No. 245, 79946 (Dec. 20, 2000).

The Board requires that pneumoconiosis be a “contributing cause” of the miner’s disability. *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(*en banc*), *overruling Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988). Additionally, the Fourth Circuit Court of Appeals requires that pneumoconiosis be a “contributing cause” of the claimant’s total disability.¹⁸ *Toler v. Eastern Associated Coal Co.*, 43 F. 3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing “the Administrative Law Judge [to] determine whether [the claimant] suffers from a respiratory or pulmonary impairment that is totally disabling and whether [the claimant’s] pneumoconiosis contributes to this disability.” *Street*, 42 F.3d 241 at 245.

Since I have found that the evidence of record fails to establish, by a preponderance of the evidence, that Mr. Marcum has coal workers’ pneumoconiosis, I accordingly find that Mr. Marcum has failed to establish that he suffers from a total respiratory disability as a result of having coal workers’ pneumoconiosis, as required by the Act and Regulations.

ATTORNEY FEES

The award of attorney’s fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion I find that the evidence of record fails to establish: one, that Mr. Marcum

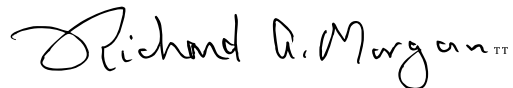
the issues of total disability and causation are independent; therefore, administrative law judges need not reject a Doctor’s opinion on causation simply because the doctor did not consider the claimant’s respiratory impairment to be totally disabling.

¹⁸ *Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). Under *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35 (4th Cir. 1990), the terms “due to,” in the statute and regulations, means a “contributing cause,” not “exclusively due to.” In *Roberts v. West Virginia C.W.P. Fund & Director, OWCP*, 74 F.3d 1233 (1996 WL 13850)(4th Cir. 1996)(Unpublished), the Court stated, “So long as pneumoconiosis is a ‘contributing’ cause, it need not be a ‘significant’ or substantial’ cause.” *Id.*

has pneumoconiosis and two, that Mr. Marcum suffers from a total respiratory disability due to pneumoconiosis.

ORDER

It is ordered that the claim of LLOYD MARCUM for benefits under the Black Lung Benefits Act is hereby DENIED.

A handwritten signature in black ink that reads "Richard A. Morgan" followed by a small "TT" superscript.

RICHARD A. MORGAN
Administrative Law Judge

RAM:LW:dmr

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits review Board within 30 days from the date of this Order by filing a Notice of Appeal with the Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific- ations	Film Qual- ity	ILO Classif- ication	Interpretation or Impression
DX-39	7-10-70 7-10-70	Daniel	N/A		-----	Calcified granulomata noted in left apex
DX-39	4-8-77 4-9-77	Daniel	N/A		-----	Calcified granuloma noted in left apex
DX-39	8-16-78 8-16-78	Rogers	N/A		-----	Calcified granuloma in left apex; lungs expanded and free of infiltrates
DX-39	6-2-80 6-2-80	Thompson	N/A		-----	Heart, lungs and bony thorax within normal limits except for small calcified granuloma in left apex
DX-39	6-23-80 6-24-80	Mardiat	N/A		-----	No acute pulmonary disease
DX-39	7-27-82 7-28-82	Thompson	N/A		-----	Calcified granuloma of left apex, lung fields clear of active inflammation
DX 22, 40	9-12-93 8-29-97	Wiot	BCR-B	1	0/0	Negative
DX 22, 40	9-12-93 9-9-97	Shipley	BCR-B	1	0/0	Negative
DX 22, 40	9-12-93 9-17-97	Spitz	BCR-B	1	0/0	Negative
DX 23	9-12-93 3-5-00	Zaldivar	B	1	0/0	Negative
DX 35	9-12-93 10-18-00	Wheeler	BCR-B	2	0/0	No evidence of pneumoconiosis
DX 35	9-12-93 10-18-00	Scott	BCR-B	2	0/0	No evidence of pneumoconiosis
EX 1	9-12-93 11-16-00	Kim	BCR-B	2	0/0	No evidence of pneumoconiosis
CX 1	9-12-93 5-25-01	Alexander	BCR-B	1	½, p/q	
CX 7	9-12-93 1-11-02	Cohen	B	1	1/0, q/t, 6 zones	
DX 22, 40	12-10-93 8-29-97	Wiot	BCR-B	U/r		No evidence of pneumoconiosis
DX 22, 40	12-10-93 9-9-97	Shipley	BCR-B	U/r		No evidence of pneumoconiosis
DX 22, 40	12-10-93 9-17-97	Spitz	BCR-B	2	0/0	Film is completely negative

* A- A-reader; B- B-reader; BCR- Board-Certified Radiologist; R- Radiologist; BCP-Board-Certified Pulmonologist; BCI Board-

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific- ations	Film Qual- ity	ILO Classif- ication	Interpretation or Impression
DX 23	12-10-93 3-15-00	Zaldivar	B	U/r		Film is unreadable
DX 35	12-10-93 10-18-00	Wheeler	BCR-B	2	0/0	No evidence of pneumoconiosis
DX 35	12-10-93 10-18-00	Scott	BCR-B	2	0/0	No evidence of pneumoconiosis
EX 1	12-10-93 11-16-00	Kim	BCR-B	2	0/0	No evidence of pneumoconiosis
CX 7	12-10-93 1-11-02	Cohen	B	U/r		Film is unreadable
DX 22, 40	2-12-94 8-29-97	Wiot	BCR-B	2	0/0	Negative
DX 22, 40	2-12-94 9-9-97	Shipley	BCR-B	1	0/0	Negative
DX 22, 40	2-12-94 9-17-97	Spitz	BCR-B	1	0/0	Negative
DX 23	2-12-94 3-5-00	Zaldivar	B	3	0/0	Negative
DX 35	2-12-94 10-18-00	Wheeler	BCR-B	2	0/0	No evidence of pneumoconiosis
DX 35	2-12-94 10-18-00	Scott	BCR-B	1	0/0	No evidence of pneumoconiosis
EX 1	2-12-94 11-16-00	Kim	BCR-B	1	0/0	No evidence of pneumoconiosis
CX 1	2-12-94 5-25-01	Alexander	BCR-B	2	½, p/q	
CX 7	2-12-94 1-22-02	Cohen	B	1	1/0, q/t, 6 zones	
DX 39	8-31-94 9-94	C.R. Daniel	BCR	1	0/0	No evidence of pneumoconiosis
DX 39	8-31-94 10-94	Gaziano	B	1	0/1, t/t	
DX 36	5-22-96 12-10-96	Castle	B	1	0/1, s/s	
DX 40	5-22-96 6-10-96	Patel	BCR	1	1/1, p/p	

Certified Internal Medicine; BCCC- Board-Certified Critical Care. Readers who are board- certified radiologists and/ or B-readers are classified as the most qualified. B-readers need not be radiologists.

** The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). ILO-UICC/Cincinnati Classification of Pneumoconiosis - The most widely used system for the classification and interpretation of x-rays for the disease

pneumoconiosis. This classification scheme was originally devised by the International Labour Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs. In some instances, it is proper for the judge to infer a negative interpretation where

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific- ations	Film Qual- ity	ILO Classif- ication	Interpretation or Impression
DX 40	5-22-96 5-7-96	Alexander	BCR-B	1	½, p/q	
DX 40	5-22-96 7-10-96	Francke	BCR-B	1	0/0	Negative
DX 21, 40	5-22-96 1-30-97	Shipley	BCR-B	2	0/0	No evidence of pneumoconiosis
DX 21, 40	5-22-96 2-12-97	Wiot	BCR-B	1	0/0	No evidence of pneumoconiosis
DX 21, 40	5-22-96 2-20-97	Spitz	BCR-B	1	0/0	No evidence of pneumoconiosis
DX 19, 40	2-19-97 3-22-97	Castle	B	2	0/1, t/s	
DX 20, 40	2-19-97 4-18-97	Wiot	BCR-B	2	0/0	Negative
DX 20, 40	2-19-97 4-28-97	Shipley	BCR-B	3	0/0	Negative
DX 20, 40	2-19-97 5-21-97	Spitz	BCR-B	1	0/0	Negative
DX 20, 40	2-19-97 9-10-97	Cole	BCR-B	1	0/0	Negative
DX 23	2-19-97 3-5-00	Zaldivar	B	1	0/0	Negative
DX 35	2-19-97 10-18-00	Wheeler	BCR-B	2	0/0	No evidence of pneumoconiosis
DX 35	2-19-97 10-18-00	Scott	BCR-B	2	0/0	No evidence of pneumoconiosis
EX 1	2-19-97 11-16-00	Kim	BCR-B	2	0/0	Negative
CX 1	2-19-97 5-25-01	Alexander	BCR-B	1	½, p/q	
CX 7	2-19-97 1-11-01	Cohen	B	1	1/0, q/t, 6 zones	
DX 40	10-15-98 10-15-98	Graham	N/A			Bilateral hyperinflation and flattening of both hemidiaphragms suggestive of underlying emphysematous changes
DX 13	3-23-00 3-23-00	Gaziano	B	1	1/0, q/s	

the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307

(1983)(Decided under Part 727 of the Regulations).

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific- ations	Film Qual- ity	ILO Classif- ication	Interpretation or Impression
DX 14	3-23-00 4-3-00	Navani	BCR-B	2	1/1, p/p	
DX 31	3-23-00 8-12-00	Wheeler	BCR-B	2	0/0	Negative for CWP
DX 31	3-23-00 7-31-00	Scott	BCR-B	2	0/0	Negative for CWP
DX 30	3-23-00 8-21-00	Kim	BCR-B	2	0/0	Negative for CWP
DX 32	3-23-00 9-1-00	Wiot	BCR-B	2	0/0	Negative for CWP
DX 33	3-23-00 9-17-00	Spitz	BCR-B	1	0/0	Negative
DX 34	3-23-00 9-30-00	Shipley	BCR-B	3	0/0	Negative for CWP
EX 2	3-23-00 1-8-01	Castle	B	1	0/1, t/q	Bullae calcified granuloma
EX 2	3-23-00 1-16-01	Hippensteel	B		0/1, t/q	Scattered calcified granulomas
CX 1	3-23-00 5-25-01	Alexander	BCR-B	1	½, p/q	
CX 2	3-23-00 6-27-01	Ahmed	BCR-B	1	½, q/p	COPD
CX 3	3-23-00 7-6-01	Aycoth	BCR-B	1	½, p/q	
CX 4	3-23-00 6-26-01	Cappiello	BCR-B	1	2/1, p/q	
CX 5	3-23-00 7-3-01	Miller	BCR-B	1	½, p/q	COPD
CX 6	3-23-00 7-17-01	Pathak	BCR-B	1	2/2, p/q	
DX 24	3-29-00 4-30-00	Zaldivar	B	1	0/0	Negative
DX 25	3-29-00 5-10-00	Wheeler	BCR-B	2	0/0	Negative for CWP
DX 25	3-29-00 5-10-00	Scott	BCR-B	2	0/0	Negative

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific- ations	Film Qual-ity	ILO Classif- ication	Interpretation or Impression
DX 28	3-29-00 6-2-00	Kim	BCR-B	2	0/0	Negative for CWP
CX 7	7-10-01 1-11-02	Cohen	B	2	1/0, q/t, 6 zones	
CX 9	7-10-01 1-23-02	Aycoth	BCR-B	1	2/1, q/t, 6 zones	
CX 10	7-10-01 1-28-01	Cappiello	BCR-B	2	2/1, p/q, 6 zones	COPD
CX 11	7-10-01 1-31-02	Miller	BCR-B		1/ 2, t/q, 6 zones	COPD
CX 12	7-10-01 2-4-02	Pathak	BCR-B	2	2/2, p/p, 6 zones	Emphysema
CX 8	7-10-01 2-5-02	Ahmed	BCR-B	2	2/2, s/t, 6 zones	Emphysema